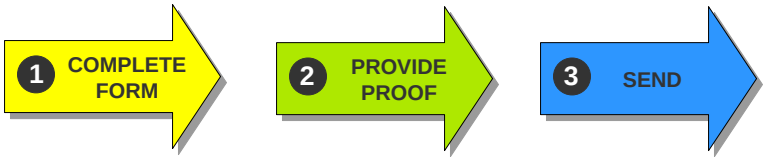
Submitting Your FSA Dependent Care Claim

How To File a Dependent Care Claim

To successfully complete a Dependent Care reimbursement request, you must submit a *Dependent Care Claim Form* along with documentation or provider acknowledgement that clearly shows an eligible service(s) was provided. To submit for reimbursement of a Dependent Care expense(s), please:

1. Complete *a Dependent Care Claim Form*
2. Attach itemized receipt(s) or have your Dependent Care Provider sign the form
3. Send us the Form and the receipt(s)



The *Claim Form* must be completed entirely, dated and signed. If providing receipts, the receipt(s) must state the provider name, provider contact information, the dependent name, service dates (begin and end), a description of the service(s) and the expense amount. A credit card receipt or canceled check is not adequate documentation. Credit card receipts often do not list the services provided along with a description of the service. This is why you must save your service receipts, if available.

If your Dependent Care Provider does not give receipts, you must have the provider sign and date the form where indicated. When using a provider signature as proof of expense, the provider's taxpayer ID or Social Security Number must be provided in the Expense Information section of the form. Dependent Care claims cannot be processed for payment without eligible documentation or provider acknowledgement.

Retain your original receipt(s), if available, and send clear photocopies with your Claim Form to ADP. You may submit up to four (4) expenses on a single Dependent Care Claim Form, using a separate line for each expense. Please fax (fastest process) OR mail the documents (keep a copy) but please DO NOT DO BOTH.

Fax: 866-392-4090 (toll-free) or 678-762-5900.

Place the documents in this order: Dependent Care Claim Form first, then the receipt(s), if available. Please do not return the instruction pages with your Claim.

OR

Mail: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.

Good Receipt

Happy Kids Day Care
125 Main Street
Smallville, CA 12345
(999) 555-1313

Billing For: Sara Sample
1414 Elm Street
Smallville, CA 12345
Child Name: Jeffrey Sample

Dates	Service Type	Amount
January 4 – 8, 2001	Daily Child Care, toddler group	$ 375.00

Receipt Missing Information

Happy Kids Day Care
125 Main Street
Smallville, CA 12345
(999) 555-1313

DATE: 01-08-2001 TIME: 05:43PM

ITEM: 0041 VIS SALE
ACCT: XXXXXXXXXXXX9876
AUTH: 9898

TOTAL: $375.00

I AGREE TO PAY THE ABOVE AMOUNT ACCORDING TO CARD ISSUER AGREEMENT (MERCHANT AGREEMENT IF CREDIT VOUCHER)

x _____

no description of items purchased

Why Providing Documentation Is Important

The IRS has provided strict requirements stating that expenses reimbursed through a Flexible Spending Account be substantiated using itemized receipts or provider acknowledgement. All supporting documentation must reflect the provider name, provider contact information, dependent name, service dates (begin and end), a description of the service(s) and the service amount(s). Dependent Care claims submitted without proof of expense cannot be approved for payment, per IRS regulations. If your claim is declined for improper proof of expense, or if the expense is deemed as ineligible, you will be notified via U.S. Mail Service.

Additional Information and Resubmitting an FSA Claim

Important Information About Dependent Care Service Dates and Expense Reimbursement

IRS regulations place strict guidelines on reimbursements for Dependent Care expenses. The biggest point of confusion in these regulations is the difference between when an expense is paid versus when an expense is "incurred". Per IRS regulations, expenses must be fully "incurred" prior to receiving reimbursement. This means the service must have been fully provided and completed for the service period. This is an important point for Dependent Care expenses because most providers require payment at the beginning of the service period. Consider the following scenario:

Sara has a young son, Jeffrey, in daycare. Sara uses daycare services while she works, Monday – Friday. She pays her daycare provider weekly on Mondays. When she takes Jeffrey to daycare on Monday, January 4, she pays the provider for the week. The service period for which she is paying is Monday, January 4, through Friday, January 8. She is paying for services in advance.

So when can Sara receive her reimbursement for this expense? According to IRS regulations, Sara cannot receive reimbursement for this expense prior to January 9, after the service period (January 4 – 8) has been completed and all services for that period have been provided in full. It is at this point that expenses have been fully "incurred".

Under these regulations, it is important that your receipts indicate the full service period covered by the payment, including begin date and end date. You should also be sure to use the Ending Service Date when completing your Dependent Care Claim Form (see Page 3 for complete instructions).

For additional information on Dependent Care reimbursements, please contact your Participant Solution Center or visit our website at www.flexdirect.apd.com/mifsa.

Resubmitting an FSA Claim When Additional Information is Requested

On occasion, you may be asked to resubmit a claim because information you provided was not sufficient, you neglected to provide required information such as a qualified receipt or perhaps you just forgot to sign the claim form. In the event you are asked to resubmit a claim, you must submit a new claim form with the requested information.

Depending on the situation, it may not be necessary to resubmit the entire claim. For example, if you filed a claim with four expenses and only one expense required additional information, you would file a new claim for that one expense with its supporting documentation. You should not resubmit the entire claim with all four expenses as this will result in duplicating the other three expenses and you would receive a letter indicating that these expenses had been duplicated. However, if you forgot to include receipts or if you neglected to sign your claim form, it would be necessary to resubmit the entire claim with all its supporting documentation.

For questions or additional information on resubmitting claims, please contact your Participant Solution Center or visit our website at www.flexdirect.adp.com/mifsa.

Filing Multiple Expenses with the Same Service Date, Same Amounts

There may be times when you need to submit multiple expenses for the same amounts that were incurred on the same date. For example, you have two children who are both in daycare. Both children have identical daycare expenses for the same service periods. It seems logical that you would file a separate claim form for each child. However, the ADP Claim System automatically reads claims based on the service date and amount and compares those dates and amounts to claims you have already submitted. By filing a separate claim form for each child, the claim that is received and processed second will be marked as a duplicate claim. When submitting multiple claims with identical service date and amounts, you should submit these expenses on the same claim form, whenever possible. This will help to avoid having eligible expenses being inadvertently marked as duplicate claims.

In the event a valid claim is entered as a duplicate, please contact your Participant Solution Center to have the claim status corrected. You will receive a notification when a claim is marked as a duplicate. You can also verify the status of your claims on our website at www.flexdirect.adp.com/mifsa.

Preparing Your FSA Dependent Care Claim Form

Please do not return the instructions pages with your Claim.

The Claim Form is designed so that you may complete the form on your computer by tabbing through the designated fields and typing the required information. If you do not have access to a computer, please use black or blue ink to complete the form. Print clearly and only in the spaces provided. This form will be processed electronically.

Step 1: **Complete all Employee Information completely.** When completing the Employee Information, you should:

1. Provide your name as it appears on your paycheck. Please print your name in ALL CAPITAL letters.
2. Include your complete mailing address.
3. Include a daytime phone number where you can be reached.
4. Include your Employee ID. Remember to include leading zeros ("0") before your Employee ID to meet the required 10 digits.

Employee Information (PLEASE PRINT)

Name: SARA SAMPLE (1) — Employer Name: State of Michigan

(Please print name in ALL CAPITAL letters)

Address: 1234 Main Street (2)

City: Anytown (2) State: US (2) Zip: 12345 (2) Daytime Phone: 555-222-1234 (3)

Employee ID (4): 0 0 0 0 7 9 6 9 5 9

Instructions: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

Step 2: **Complete the Expense Information.** Be sure to include only one expense per line provided. **DO NOT** combine multiple expenses on one line. The Claim Form allows you to submit up to four (4) expenses per form. When completing the Expense Information, you should:

1. Provide the last date service(s) were provided. This date should match the date on your receipt, if provided.
2. Provide the name of the provider from whom the service(s) was received.
3. Provider the taxpayer ID or Social Security Number of the Dependent Care Provider. This information is required when no receipt is available and you are using the provider signature as proof of expense.
4. Provide information on the dependent for whom the service was provided: name, date of birth and the dependent's relationship to you (use "C" for child, "S" for Spouse or "O" for other).
5. Provide the total amount for the service.
6. Provide the total amount for all line items on this Claim Form.

Expense Information

(1) Ending Date of Service MONTH	DAY	YEAR	NOTE: Please report only one expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.		(5) Amount DOLLARS	CENTS
0 1	0 8	0 1	NAME OF PROVIDER: Happy Kids Day Care (2)			
			TAXPAYER ID OR SSN OF PROVIDER (3): 123-45-6789	DEPENDENT D.O.B (4): 01/21/1998	3 7 5	0 0
			DEPENDENT NAME (4): Jeffrey Sample	RELATIONSHIP TO EMPLOYEE: C (4)		

(6) Total Expenses → $ 3 7 5 0 0

Step 3: **Have the Dependent Care Provider sign the Claim Form.** Provider signature is only required if receipts are not available.

Dependent Care Provider Signature

SIGNATURE: Pamela Provider DATE: 01/08/01

(Necessary only if receipt is not provided)

Step 4: **Sign and date your Claim Form.** Claim forms received without an authorizing signature cannot be processed.

Certification

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I further certify that if the above expenses are not eligible, I will remit payment in the amount of the ineligible expense to the plan. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Bills, statements, receipts or other proof of the expenses are attached.

SIGNATURE: Sara Sample DATE: 01/11/01

DCID-02

Dependent Care Spending Account Claim Form

This document and any attachments are intended solely for the use of the sender and ADP and may contain information that is privileged and confidential. If you are not the intended recipient or its authorized representative, you are hereby notified that dissemination of this information is strictly prohibited. If you received this information in error, notify the sender immediately and destroy this document and all supporting attachments.

Tips to Remember

1. Sign your Claim Form.
2. Fax your Claim Form *without* a cover page. Attach proof of expense(s) or have your dependent care provider sign where indicated.
3. *Do not* include the instructions pages with your submission.

Remember! You must include leading zeros ("0") before your Employee ID to meet the required 10 digits. (EXAMPLE: 0000654321)

Employee Information (PLEASE PRINT)

Name ______________________ Employer Name **State of Michigan**

(Please print name in ALL CAPITAL letters)

Address ______________________

City ____________ State ______ Zip ______ Daytime Phone ____________

Employee ID ☐☐☐☐☐☐☐☐☐☐

Instructions: Please use blue or black ink and print like this → 0 1 2 3 4 5 6 7 8 9

Expense Information

Ending Date of Service			NOTE: Please report only one expense per block. Combining multiple expenses in one block may result in a delayed reimbursement.		Amount	
MONTH	DAY	YEAR			DOLLARS	CENTS
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE ☐		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE ☐		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE ☐		
			NAME OF PROVIDER			
			TAXPAYER ID OR SSN OF PROVIDER	DEPENDENT D.O.B.		
			DEPENDENT NAME	RELATIONSHIP TO EMPLOYEE ☐		

To Expedite Processing Please Fax Your Claim To
1-(866) 392-4090 (toll-free)
Or Mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853

Total Expenses → $ ________

Dependent Care Provider Signature

SIGNATURE ______________________ DATE ____________

(Necessary only if receipt is not provided)

Certification

I certify that the expenses listed above qualify for reimbursement under the applicable IRS regulations and guidance and have been incurred by me or by my eligible dependents. These expenses have not been reimbursed and I will not seek reimbursement under any other source. I understand that where an expense is determined to be ineligible, I am responsible for reimbursing the plan for any such expense. Additionally, these expenses are not being claimed as tax deductions under the IRS code. Bills, statements, receipts or other proof of the expenses are attached. I certify that any Dependent Care Provider Signature above was indeed provided by a valid Dependent Care Provider.

SIGNATURE ______________________ DATE ____________